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United States House of Representatives
Committee on Ways & Means, Subcommittee on Health
Hearing on the 2013 Medicare Trustees Report
June 20, 2013

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Joe Baker, President of the Medicare Rights Center. The Medicare Rights Center is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

We know firsthand the economic and health challenges facing people with Medicare. We provide answers to 15,000 Medicare questions annually on our national helpline, serving older adults, people with disabilities, family caregivers and professionals. Through our educational initiatives, we touch the lives of another 65,000 beneficiaries and their families each year.

We appreciate the opportunity to submit a written statement on the 2013 Medicare Trustees Report. Each year, the trustees offer projections on the fiscal health of the Medicare program. The trustees' recent findings confirm what we already know to be true: Medicare is *not* in crisis.

The trustees conclude that the Medicare Hospital Insurance (HI) trust fund is solvent through 2026—two years later than reported last year—and the Supplemental Medical Insurance (SMI) trust fund remains on firm financial footing, ensuring full payment for outpatient care and certain prescription drug needs.[1] After 2026, the HI trust fund will be able to pay 87% of inpatient claims, gradually declining to 71% in 2047 and then rising to 73% in 2087.[2] Insolvency is not a concern for the SMI trust fund, and the trustees presume that Medicare will be able to cover outpatient costs for the foreseeable future.[3]

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[1] The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund" (May 2013), available at: http://downloads.cms.gov/files/TR2013.pdf.
[2] P. Van de Water, "Medicare is Not Bankrupt, Health Reform Has Improved Program's Financing" (Center on Budget and Policy Priorities: June 2013), available at: http://www.cbpp.org/cms/?fa=view&id=3532.
[3] The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund" (May 2013), available at: http://downloads.cms.gov/files/TR2013.pdf; P. Van de Water, "Medicare is Not Bankrupt, Health Reform Has Improved Program's Financing" (Center on Budget and Policy Priorities: June 2013), available at: http://www.cbpp.org/cms/?fa=view&id=3532.

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According to the U.S. Department of Health and Human Services, Medicare cost growth slowed dramatically in recent years to levels "unprecedented in the history of the Medicare program."[4] Additional analysis by the S&P Dow Jones Indices illustrates that "…health care costs have decelerated over the past few years, and Medicare costs have decelerated more than other health costs."[5] While some of this slowdown is attributable to the continued effects of the economic downturn, research shows that much of this change is structural.[6]

Debate continues as to whether or not the recent slowdown in health care cost growth will persist, underscoring the difficulty of adequately projecting future Medicare spending, particularly over the long-term.[7] According to the trustees, due to unforeseeable advancements in medical technology and uncertainty surrounding the implementation of current law, "Projections of Medicare costs are highly uncertain, especially when looking out more than several decades."[8]

Despite these facts, some members of Congress firmly assert that Medicare is going bankrupt. This false claim contributes to the misguided belief that Medicare benefits must be cut to sustain the program for future generations. Towards this end, some policy makers propose shifting added costs to people with Medicare, such as by further means-testing Medicare premiums, increasing deductibles, copayments or coinsurance, or scaling back supplemental Medigap insurance coverage.

Adopted separately or in combination, each of these proposals would achieve savings for the federal government while also worsening the already fragile economic and health status of many people with Medicare. Added health care costs impose financial hardship, particularly for those living on low- and moderate-incomes, and increased cost sharing leaves many beneficiaries with no choice but to self-ration care. Faced with higher upfront costs, beneficiaries living on fixed-incomes are likely to forgo doctors' visits altogether—a decision made on the basis of affordability as opposed to need.[9]

Based in part on the findings of the 2013 Medicare Trustees Report, we believe that there is no justification for policy interventions that would shift added costs to people with Medicare. Most people with Medicare cannot afford to pay more. Half of all beneficiaries—25 million older adults and people

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[4] Office of the Assistant Secretary for Planning and Evaluation, "Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows" (DHHS: January 2013), available at: http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.cfm.

[5] S&P Dow Jone Indices, "Press Release: Deceleration in Annual Growth Rate for All Nine Indices in June 2012, According to the S&P Healthcare Economic Indices" (January 2012); J. Weisenthal, "Peter Orszag's Chart Of The Year Could Change Everything You Think About Healthcare And The Federal Budget" (*Business Insider*: December 2012), available at: http://www.businessinsider.com/peter-orszag-chartshows-medicare-costs-slowing-2012-12.

[6] A. Ryu, T. Gibson, McKeller, M.R., and M.E. Chernew, "The Slowdown in Health Care Spending in 2009-11 Reflected Factors Other Than the Weak Economy and Thus May Persist" (*Health Affairs*: May 2013); D. Cutler and N.R. Sahni, "If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off $770 Billion" (*Health Affairs*: May 2013)

[7] L. McGinley, "Are slower-growing health care costs temporary or permanent?"(*Washington Post*: June 2013), available at: http://www.washingtonpost.com/blogs/wonkblog/wp/2013/06/18/are-slower-growing-health-care-costs-temporary-or-permanent/.

[8] The Board of Trustees, "2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund" (May 2013), available at: http://downloads.cms.gov/files/TR2013.pdf.

[9] For a more detailed analysis on the harms of added cost sharing, see: J. Baker, "Testimony Prepared for the United States House Committee on Ways & Means, Subcommittee on Health on 'The President's and Other Bipartisan Proposals to Reform Medicare'" (May 2013), available at: http://waysandmeans.house.gov/uploadedfiles/baker_testimony_final_hl_052113.pdf.

with disabilities—live on annual incomes of $22,500 or less. And people with Medicare already spend a significant amount on health care. The average Medicare household spends 15% of their annual income on out-of-pocket health care costs—three times that of non-Medicare households.[10]

Rather than shifting added costs to people with Medicare, we urge members of Congress to advance value-driven delivery system and payment reforms designed to improve health care quality while simultaneously driving down the cost of health care. The Affordable Care Act (ACA) offers a blueprint for these reforms, and testing of many promising solutions is underway. Already a proven leader in cost-control, Medicare is the incubator for these innovations.

The 2013 Medicare Trustees Report confirms that cost-control mechanisms in the ACA, such as scheduled payment adjustments to Medicare private health plans and efforts to combat fraud and abuse, significantly improved the fiscal outlook for the Medicare program. In addition to testing and expanding promising delivery system reforms, these provisions must be implemented to the full extent.

More can be done to put the Medicare program on strong financial footing. Towards this end, we ask members of Congress to support prudent cost containment that neither harms nor shifts costs to people with Medicare. Examples of these solutions include reducing wasteful spending on Medicare pharmaceutical drugs and medical equipment and further equalizing payments to private Medicare health plans.[11]

Short-sighted approaches that shift costs to people with Medicare will not only harm older adults and people with disabilities, but will also achieve only short-term savings. Instead, policymakers must focus on the long-term challenges facing our health care system overall. Transforming how we pay for health care services and eliminating wasteful spending is the right path forward.

Thank you for the opportunity to provide comment.

Sincerely,

Joe Baker
President

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[10] J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicarebeneficiaries-costs-and-service-use-testimony.pdf.

[11] Medicare Rights Center, "Build on What Works: Medicare Cost Savers" (June 2013), available at: http://www.medicarerights.org/pdf/Medicare-Cost-Savers.pdf.

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